## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013 FORM APPROVED OMB NO. 0938-0391

MARE OF PROVIDER OR SUPPLIER TERRACE AT SOLARBRON THE  STREET ADDRESS, CITY, STATE, ZIP CODE 1701 MICROWIEL NO PREFIX TAG  STREET ADDRESS, CITY, STATE, ZIP CODE 1701 MICROWIEL NO PREFIX TAG  STREET ADDRESS, CITY, STATE, ZIP CODE 1701 MICROWIEL NO PROVIDERS LAND OF CORRECTION PREFIX TAG  SUPPLIENT TAG  REQULATORY OR LISC IDENTIFYING INFORMATION)  [K 000]  INITIAL COMMENTS  A Post Survey Review (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 08/27/13 was conducted by the Indians State Department of Health in accordance with 42 CFR 483.70(a).  Survey Date: 11/01/13  Facility Number: 105930 Provider Number: 155773 AIM Number: N/A  Surveyor: Lex Brashear, Life Safety Code Specialist  At this PSR survey, The Terrace at Solarbron was found in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.  This facility was located on the first floor of a two story building determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire latent system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident rooms. The facility has a capacity of 109 and had a census of 51 at the time of this survey.  All areas where residents have customary access were sprinklered. A Literas providing facility services were sprinklered, except a detached maintenance garage used for the storage of	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING <b>02</b>		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
TERRACE AT SOLARBRON THE    SALARBRON THE   SUMMARY STATEMENT OF DEPICIENCIES   PRETEX ADDRESS. CITY, STATE, ZIP CODE   1701 MCDOWELL IN 47712   PROVIDER'S FLAN OF CORRECTION   COMMANDER   PRETEX FLAN OF CORRECTION   COMMANDER   CANCELLA FLOW OR I.SC IDENTIFYINS INFORMATION)   PRETEX FLAN OF CORRECTION   CANCELLA FLOW OR I.SC IDENTIFYINS INFORMATION)   PRETEX FLAN OF CORRECTION OF CANCELLA FLOW OR I.SC IDENTIFYINS INFORMATION)   PRETEX FLAN OF CORRECTION   CANCELLA FLOW OR I.SC IDENTIFYINS INFORMATION)   PRETEX FLAN OF CORRECTION   CANCELLA FLOW OR I.SC IDENTIFYINS INFORMATION   PRETEX FLAN OF CORRECTION   CANCELLA FLOW OR I.SC IDENTIFYINS INFORMATION   PRETEX FLAN OF CORRECTION   CANCELLA FLOW OR I.SC IDENTIFYING INFORMATION   PRETEX FLAN OF CORRECTION   CANCELLA FLAN OF CANCELLA FLAN OF CORRECTION   CANCELLA FLAN OF CORRECTION   CANCELLA FLAN OF CORRECTION   CANCELLA FLAN OF CORRECTION   CANCELLA FLAN OF CA			155773	B. WING			1	
PREFIX TAG   IRACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   IRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY					1701	MCDOWELL RD	•	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	LADODATORY	were sprinklered. All services were sprinkle maintenance garage	areas providing facility ered, except a detached used for the storage of			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 02			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	199779	STREET ADDRESS, CITY, STATE, ZIP CODE  1701 MCDOWELL RD  EVANSVILLE, IN 47712				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{K 000}	maintenance equipme		{K 0	00)			